DIVISION OF HEALTH CARE FINANCING AND POLICY – NEVADA MEDICAID

ICF/MR TRACKING FORM

TO BE SUBMITTED WITHIN 72 HOURS OF ANY OCCURRENCE LISTED BELOW
FOR MEDICAID ELIGIBILE INDIVDUALS ONLY

Recipient's Last Name: _____First Name: _____ MI: _____

Medicaid Billing #: _____ Social Security #:_____Date of Birth: _____

SECTION I

ADMISSION/PAYMENT INFORMATION: ☐ Attachments Included

Facility Name: _____

Provider Number:_____

Facility admission date: _____

Resident admitted from: _____

Dates of Stay: From _____ To _____

Reason for Payment Request

☐ New admission ☐ Re-admission ☐ Retro-Eligible ☐ Eligibility Reinstated

SECTION II

DISCHARGE INFORMATION

Discharge Date: _____

Reason for Discharge:

☐ Home or Community Based Living ☐ Hospital ☐ Death ☐ Transfer (to another facility): _____

☐ Other _____

Form Completed By: _____Date:_____
(Please print legibly)

Failure of the facility to submit this tracking form within 72 hours of any occurrence listed below may result in payment delays or denials.